BEFORE THE
OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

FILED

DEC 22 2010

OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

In the Matter of the Accusation Against: **PO-LONG LEW, D.O.** **9308 East Valley Blvd.** **Rosemead, CA 91770** **Osteopathic Physician and Surgeon's License No. 20A 5380** Respondent.	Case No. 00-2006-001753 OAH No. L2008080570

DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order is hereby adopted by the Osteopathic Medical Board of California, Department of Consumer Affairs, as its Decision in this matter.

This Decision shall become effective on January 5, 2011.

It is so ORDERED December 22, 2010.

FOR THE OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

GERALDINE O'SHEA, D.O., PRESIDENT

EDMUND G. BROWN JR.
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ORIGINAL

BEFORE THE
OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **PO-LONG LEW, D.O.** **9308 East Valley Blvd.** **Rosemead, CA 91770** **Osteopathic Physician and Surgeon's License No. 20A 5380** Respondent.	Case No. 00-2006-001753 OAH No. L2008080570 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

In the interest of a prompt and speedy settlement of this matter, consistent with the public interest and the responsibility of the Osteopathic Medical Board of California of the Department of Consumer Affairs, the parties hereby agree to the following Stipulated Settlement and Disciplinary Order which will be submitted to the Board for approval and adoption as the final disposition of the Accusation.

PARTIES

1. Donald J. Krpan, D.O. (Complainant) is the Executive Director of the Osteopathic Medical Board of California. He brought this action solely in his official capacity and is

represented in this matter by Edmund G. Brown Jr., Attorney General of the State of California, by Richard D. Marino, Deputy Attorney General.

2. Respondent Po-Long Lew, D.O. (Respondent) is represented in this proceeding by attorney Alexander W. Kirkpatrick Esq., whose address is 790 East Colorado Boulevard, 9th Floor, Pasadena, CA 91101.

3. On or about July 1, 1987, the Osteopathic Medical Board of California issued Osteopathic Physician and Surgeon's License No. 20A 5380 to Po-Long Lew, D.O. (Respondent). The Osteopathic Physician and Surgeon's License was in full force and effect at all times relevant to the charges brought in Accusation No. 00-2006-001753 and will expire on November 30, 2011, unless renewed.

JURISDICTION

4. Accusation No. 00-2006-001753 was filed before the Osteopathic Medical Board of California (Board), Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on July 9, 2008. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 00-2006-001753 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 00-2006-001753. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel at his own expense; the right to confront and cross-examine the witnesses against him; the right to

present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent understands and agrees that the charges and allegations in Accusation No. 00-2006-001753, if proven at a hearing, constitute cause for imposing discipline upon his Osteopathic Physician and Surgeon's License.

9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

10. Respondent agrees that his Osteopathic Physician and Surgeon's License is subject to discipline and he agrees to be bound by the Osteopathic Medical Board of California (Board) 's imposition of discipline as set forth in the Disciplinary Order below.

RESERVATION

3. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Osteopathic Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

4. This stipulation shall be subject to approval by the Osteopathic Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the

Osteopathic Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

5. The parties understand and agree that facsimile copies of this Stipulated Settlement and Disciplinary Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

6. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Osteopathic Physician and Surgeon's License No. 20A 5380, issued to Respondent Po-Long Lew, D.O. (Respondent), is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions.

1. **Obey All Laws.** Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments and other orders.

2. **Quarterly Reports.** Respondent shall submit to the Board quarterly declaration under penalty of perjury on the Quarterly Report of Compliance Form, OMB 10 (5/97) which is hereby incorporated by reference, stating whether there has been compliance with all the conditions of probation.

3. **Probation Surveillance Program.** Respondent shall comply with the Board's

probation surveillance program. Respondent shall, at all times, keep the Board informed of his addresses of business and residence which shall both serve as addresses of record. Changes of such addresses shall be immediately communicated in writing to the Board. Under no circumstances shall a post office box serve as an address of record.

Respondent shall also immediately inform the Board, in writing, of any travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) days.

4. **Interviews With Medical Consultants.** Respondent shall appear in person for interviews with the Board's medical consultants upon request at various intervals and with reasonable notice.

5. **Cost Recovery.** The Respondent is hereby ordered to reimburse the Board the amount of $20,000 in 12 equal quarterly installments, the first of which due 90 days from the effective date of this decision, for its investigative and prosecution costs. Failure to reimburse the Board's cost of its investigation and prosecution shall constitute a violation of the probation order, unless the Board agrees in writing to payment by an installment plan because of financial hardship.

6. **License Surrender.** Following the effective date of this decision, if Respondent ceases practicing due to retirement, health reasons, or is otherwise unable to satisfy the terms and conditions of probation, Respondent may voluntarily tender his certificate to the Board. The Board reserves the right to evaluate the Respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the tendered license, Respondent will no longer be subject to the terms and conditions of probation.

7. **Tolling for Out-of-State Practice or Residence, or In-State Non-Practice (Inactive License).** In the event Respondent should leave California to reside or to practice outside the State or for any reason should Respondent stop practicing medicine in California, Respondent shall notify the board or its designee in writing within ten days of the dates of departure and return or the dates of non-practice within California. Non-practice is defined as

any period of time exceeding thirty days in which Respondent is not engaging in any activities defined in Section 2051 and/or 2052 of the Business and Professions Code. All time spent in an intensive training program approved by the Board or its designee in or out of state shall be considered as time spent in the practice of medicine. Periods of temporary or permanent residence or practice outside California or of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary period.

8. **Probation Violation/Completion of Probation.** If Respondent violates probation in any respect, the Board may revoke probation and carry out the disciplinary order that was stayed after giving Respondent notice and the opportunity to be heard. If an Accusation and/or Petition to revoke is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final. Upon successful completion of probation, Respondent's certificate will be fully restored.

9. **Physician Enhancement Program.** Within 60 days of the effective date of this decision, Respondent shall enroll in the Physician Enhancement Program, offered through the Physician Assessment and Clinical Education (PACE) Program of the University of California, at San Diego, School of Medicine, as described in Exhibit B. If Respondent fails to complete this program within a timely manner as determined by PACE and the Board has not agreed, in writing, to allow Respondent additional time within which to complete the program, Respondent shall cease the practice of medicine until the program has been completed and the Respondent has been so notified by the Board in writing.

10. **Early Termination of Probation.** Notwithstanding the proscriptions set forth in Business and Professions Code section 2307, Respondent may apply for early termination of probation at the end of the first year of probation if he has successfully completed the Physician Enhancement Program and paid to the Board the full amount of cost recovery.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Alexander W. Kirkpatrick Esq.. I understand the stipulation and the effect it will have on my Osteopathic Physician and Surgeon's License. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Osteopathic Medical Board of California.

DATED: 3/29/10

PO-LONG LEW, D.O.
Respondent

I have read and fully discussed with Respondent Po-Long Lew, D.O. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 3/29/2010

Alexander W. Kirkpatrick Esq.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Osteopathic Medical Board of California of the Department of Consumer Affairs.

Dated: March 25, 2010

Respectfully Submitted,

EDMUND G. BROWN JR.
Attorney General of California
PAUL C. AMENT
Supervising Deputy Attorney General

RICHARD D. MARINO
Deputy Attorney General
Attorneys for Complainant

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Stipulation.rtf

Exhibit A

Accusation No. 00-2006-001753

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Attorneys for Complainant

BEFORE THE
OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: PO-LONG LEW, D.O. 9308 East Valley Blvd. Rosemead, CA 91770 Osteopathic Physician and Surgeon's License No. 20A 5380 Respondent.	Case No. 00-2006-001753 **ACCUSATION**

Complainant alleges:

PARTIES

1. Donald J. Krpan, D.O. (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Osteopathic Medical Board of California, Department of Consumer Affairs.

2. On or about July 1, 1987, the Osteopathic Medical Board of California issued Osteopathic Physician and Surgeon's License Number 20A 5380 to Po-Long Lew, D.O. (Respondent). The Osteopathic Physician and Surgeon's License was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2009, unless renewed.

JURISDICTION

3. This Accusation is brought before the Osteopathic Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws.

4. Business and Professions Code section 2450 provides:

"There is a Board of Osteopathic Examiners of the State of California, established by the Osteopathic Act, which shall be known as the Osteopathic Medical Board of California which enforces this chapter relating to persons holding or applying for physician's and surgeon's certificates issued by the Osteopathic Medical Board of California under the Osteopathic Act. Persons who elect to practice using the term of suffix 'M.D.,' as provided in Section 2275, shall not be subject to this article, and the Medical Board of California shall enforce the provisions of this chapter relating to persons who made the election."

5. Business and Professions Code section 2450.1 provides:

"Protection of the public shall be the highest priority for the Osteopathic Medical Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount."

6. Business and Professions Code section 2451 provides:

"The words 'Medical Board of California,' the term 'board,' or any reference to a division of the Medical Board of California as used in this chapter shall be deemed to mean the Osteopathic Medical Board of California, where that board exercises the functions granted to it by the Osteopathic Act."

7. Business and Professions Code section 2220, in conjunction with Business and Professions Code sections 3600[1] and the Osteopathic Act, authorize the Osteopathic Medical

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1. Bus. & Prof. Code § 3600 provides:

"The law governing licentiates of the Osteopathic Medical Board of

Board of California to take action against "all persons guilty of violating th[e] [Medical Practice Act]."

8. Business and Professions Code section 2234, in relevant part, provides:

"The [Board] shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

". . . ."

9. Business and Professions Code section 2261 provides:

"Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

10. Business and Professions Code section 2266 provides:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

11. Business and Professions Code section 2285, in relevant part, provides:

California is found in the Osteopathic Act and in Chapter 5 of Division 2, relating to medicine. "

"The use of any fictitious, false, or assumed name, or any name other than his or her own by a licensee either alone, in conjunction with a partnership or group, or as the name of a professional corporation, in any public communication, advertisement, sign, or announcement of his or her practice without a fictitious-name permit obtained pursuant to Section 2415[2] constitutes

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2. Bus. & Prof. Code § 2415 provides:

"(a) Any physician and surgeon or any doctor of podiatric medicine, as the case may be, who as a sole proprietor, or in a partnership, group, or professional corporation, desires to practice under any name that would otherwise be a violation of Section 2285 may practice under that name if the proprietor, partnership, group, or corporation obtains and maintains in current status a fictitious-name permit issued by the Division of Licensing, or, in the case of doctors of podiatric medicine, the California Board of Podiatric Medicine, under the provisions of this section.

"(b) The division or the board shall issue a fictitious-name permit authorizing the holder thereof to use the name specified in the permit in connection with his, her, or its practice if the division or the board finds to its satisfaction that: (1) The applicant or applicants or shareholders of the professional corporation hold valid and current licenses as physicians and surgeons or doctors of podiatric medicine, as the case may be. (2) The professional practice of the applicant or applicants is wholly owned and entirely controlled by the applicant or applicants. (3) The name under which the applicant or applicants propose to practice is not deceptive, misleading, or confusing.

"(c) Each permit shall be accompanied by a notice that shall be displayed in a location readily visible to patients and staff. The notice shall be displayed at each place of business identified in the permit.

"(d) This section shall not apply to licensees who contract with, are employed by, or are on the staff of, any clinic licensed by the State Department of Health Services under Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code or any medical school approved by the division or a faculty practice plan connected with that medical school.

"(e) Fictitious-name permits issued under this section shall be subject to Article 19 (commencing with Section 2420) pertaining to renewal of licenses, except the division shall establish procedures for the renewal of fictitious-name permits every two years on an anniversary basis. For the purpose of the conversion of existing permits to this schedule the division may fix prorated renewal fees.

"(f) The division or the board may revoke or suspend any permit issued if it finds that the holder or holders of the permit are not in compliance with the provisions of this section or any regulations adopted pursuant to this section. A proceeding to revoke or suspend a fictitious-name permit shall be conducted in

unprofessional conduct."

12. Business and Professions Code section 725 of the Code provides:

"Repeated acts of clearly excessive prescribing or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, or optometrist. However, pursuant to Section 2241.5, no physician and surgeon in compliance with the California Intractable Pain Treatment Act shall be subject to disciplinary action for lawfully prescribing or administering controlled substances in the course of treatment of a person for intractable pain."

COST RECOVERY

13. Business and Professions Code section 125.3, in relevant part, provides that the Complainant may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case to the Board.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

14. Respondent's Osteopathic Physician and Surgeon's License is subject to

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accordance with Section 2230.

"(g) A fictitious-name permit issued to any licensee in a sole practice is automatically revoked in the event the licensee's certificate to practice medicine or podiatric medicine is revoked.

"(h) The division or the board may delegate to the executive director, or to another official of the board, its authority to review and approve applications for fictitious-name permits and to issue those permits.

"(i) The California Board of Podiatric Medicine shall administer and enforce this section as to doctors of podiatric medicine and shall adopt and administer regulations specifying appropriate podiatric medical name designations."

disciplinary action in that he has committed acts of gross negligence, in violation of Business and Professions Code section 2234, subdivision (b), during his care, treatment and management of patients S.M., S.K., A.M., S.B., R.S., J.H., A.A., L.M., R.M., L.T., H.C., A.S., L.M.., and E.G., as follows:

Patient S.M.

A. Patient S.M., a 31 year old male presented with symptoms of a cold and a one week history of low back pain after falling at home. Respondent prescribed antipsychotic medication–namely, Haldol–without a corresponding diagnosis, two different acetaminophen containing medications, together totaling a potentially toxic dose of acetaminophen, and antibiotics without documenting patient's allergy history. Respondent also ordered bone density testing-- a DXA scan–even though there was absolutely no indication for bone density testing.

B. The following acts and omissions, considered singularly and collectively constitute extreme departures from the standard of care:

1) Ordering bone density scan without indication.

2) Prescribing antipsychotic medications

3) Prescribing multiple acetaminophen-containing prescriptions at the same time.

4) Prescribing antibiotic medication without checking the patient's allergy records or history.

Patient M.M.

C. Patient M.M., a 41 year-old obese male, presented with complaints of total body pain, 3 days of sinus congestion and a history of diabetes and congestive heart failure. Respondent ordered a sinus x-ray and bone density testing–a DXA scan– without indication for either.

D. The following act and omission constitute an extreme departure from the standard of care:

1) Ordering bone density scan without indication.

Patient S.K.

E. Patient S.K., a 50 year-old male, initially presented to Respondent on October 18, 2005. Patient S.K.'s reported history included a fractured arm in 1998. He complained of dizziness, headache, lack of balance, a sore throat and back pain. Respondent documented additional complaints of congestion, fever, cough, shortness of breath ("SOB"), dental abscess and pain. The vital signs are notable for a blood pressure of 140/90 (elevated) and no fever. Multiple elements of the physical exam are checked as being normal, including normal female genitalia in this male patient. Respondent rendered multiple diagnoses, including hepatitis, dental abscess R/O[3] sepsis, carotid stenosis, and history of osteoporosis. Respondent apparently documented other diagnoses but none of them are legible. Respondent wrote that he wanted to rule out "TIA." No testing was done. Many medications were ordered including antibiotics, Fosamax and calcium supplements.[4]

F. Patient S.K. next presented to Respondent on December 7, 2005. Respondent recorded that the patient had symptoms of a cold for three days and wanted to know the result of his EGD.[5] There is no further mention of the EGD on this visit. Vital signs were normal. The only finding on exam was congested, red nose and lung rales. Both male and female genitalia were reportedly found to be normal. Diagnoses rendered were osteoporosis, allergic rhinitis, viral bronchitis. The patient again was given a prescription for Fosamax and calcium supplements.

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3. "R/O" is a commonly used medical shorthand for "rule out."

4. Patient S.K. requested that Respondent refill medications previously prescribed to S.K.

5. Respondent's progress notes do not include any reference to having ordered EGD testing.

G. Patient S.K. next presented to Respondent complaining of a toothache for one week. There is no further historical detail regarding this complaint. Respondent recorded a complaint of right elbow pain, but there is no detail regarding duration or trauma. In the record prepared by Respondent, all physical examination elements are checked as normal. There is no detail regarding mouth, teeth or elbow. A suboptimal x-ray of the elbow done in Respondent's office was read by him as showing a bone spur and degenerative changes. Respondent recorded several diagnoses, some of which are illegible. Those that can be read include osteoporosis, tooth pain, hepatitis B carrier. Respondent's treatment plan included antibiotics and Fosamax.

H. On April 12, 2006, Patient S.K. presented for refills. A diagnosis of GERD (heartburn) was rendered. A medication used for GERD was prescribed (Previcid), as were medications known to worsen this condition (Celebrex, Fosamax). Respondent failed to determine whether the patient's heartburn was the result of the Fosamax.

I. Respondent's medical records for Patient S.K. show that the patient next presented on September 17, 2006. However, there are two versions of this visit:

1) Version 1: Male patient presents with a chief complaint recorded as "Bloodtest [*sic*] Results." The only recorded HPI[6] is "LBP" (presumably: low back pain). There is no explanation for the inconsistency between the chief complaint and the HPI, and there is no documented historical detail regarding the "LBP". The only recorded vital sign is a blood pressure of 136/92.

6. HPI is that portion of the form calling for history and physical examination.

The documented physical exam (PE) consists of checked boxes corresponding to various elements of the PE, including "WNL ext. inspection" of ears, nose, mouth and throat & "WNL oropharynx." There is no documented exam of the low back, spine or hips. The diagnoses rendered were Hepatitis B and hyperlipidemia. The legible portion of the recorded plan is "Liver (tablet?), DEXA scan, carotid US (ultrasound), "2 M M Ms".

2) Version 2: The patient's birth date has been entered as July 6, 1938, and the chief complaint includes history of "HTN (hypertension), palpitations and dizziness." The HPI section now includes "LBP 3 days, radiating down to legs. (History of) Hepatitis B, history of hyperlipidemia." Full vital signs are now recorded. The PE section now includes auscultation of the neck and heart, which purportedly revealed "carotid bruit [*sic*]" and "heart murmur." There is decreased range of motion of an undocumented joint and the "WNL gait or posture" section is checked, with the additional notation "LBP." The presence of increased leg edema is recorded in the musculoskeletal portion of the exam document. There are illegible notations in the assessment section, presumably the results of a bone density test performed that same day. In the plan section, is recorded the results of a back x-ray (degenerative changes of L5, S1) and different

handwriting records what I believe are the results of a carotid ultrasound and echocardiogram. The number of diagnoses is expanded to include "CHF and carotid", "severe LBP" and "osteoporosis." The plan is expanded to include prescriptions for Fosamax, folic acid and Motrin.

J. The following acts and omissions by respondent, considered singularly and collectively, constitute extreme departures from the standard of care:

1) Failing to record the reasons for the discrepancies where the initial chief complaint recorded in the patient's chart differs from the real reason for the patient's visit.

2) Documenting multiple versions of the same office visit without explanation.

3) Failing to obtain and document a complete history in connection with Patient S.K.'s specific complaints of pain–e.g., lower back pain, left elbow pain.

4) Failure to perform a complete and appropriate physical examination.

5) Rendering unsupported diagnoses–e.g., osteoporosis.

6) Failing to determine whether the patient's heartburn was the result of the medication that Respondent prescribed–i.e., Fosamax.

7) Documenting inaccurate information–e.g., noting that a male patient had normal female genitalia on October 18, 2005 and on Decameter 17, 2005.

Patient A.M.

K. Patient A.M., a 52 year-old female, first presented to Respondent on April 2, 2004. She reported low back pain, high cholesterol and a history of depression. She also reported taking Dilantin. She next presented to Respondent on April 30, 2004. At that time she completed a medical history form on which it was noted that she was a smoker and taking medicine for hypertension and depression. The specific medication was not recorded. Her chief complaint was a chest pain for 3 days, associated with dizziness, shortness of breath and not relieved by nitroglycerin. Her blood pressure was 144/96 and her pulse recorded as 72. There were no abnormal findings on what was documented as a full physical exam. An EKG was distinctly abnormal with an elevated heart rate of 101 and changes suggestive of lateral ischemia. No blood tests were done. The patient was not referred to a cardiologist or directed to go to the emergency room. A diagnosis of CHF was made; the only corresponding treatment plan was a low sodium (salt) diet.

L. On May 26, 2004, Patient A.M. returned to Respondent's office, complaining of stomach pain. Her blood pressure was elevated; her recorded pulse rate was 70; and, her heart rate, according to an EKG, was 100. Her EKG continued to show ischemic changes, now in the inferior leads as well. Her blood pressure medicines were changed and she was referred to a cardiologist.

M. Over the ensuing visits, the patient's blood pressure remained elevated, and her EKG abnormal. Respondent did not refer the patient to a cardiologist and there is nothing in the patient's records showing that she had been seen by a cardiologist. Sometime in July 2004 she reported that she had suffered a recent stroke. The blood pressure is illegible. The documented neurological exam does not reflect the subsequent diagnosis of "old CVA with left hemiparesis." A variety of psychoactive medications were prescribed without a corresponding diagnosis.

N. Chest pain was reported by the patient again in August and again in November 2004. On October 17, 2004, her blood pressure was elevated and her physical exam disclosed "PAC's", a heart murmur, lung rales and wheezing. A chest x-ray was read by Respondent as showing congestive heart failure. No EKG or lab work was done; diuretics were not prescribed and there is no evidence that Respondent recommended E.R. evaluation.

O. Patient A.M. saw Respondent on multiple occasions over the ensuing 12 months. On none of the progress notes is it clear what medicines this patient was taking on an ongoing basis. The diagnoses vary from visit to visit and include schizophrenia, depression, insomnia, low back pain, seizures, umbilical hernia and hypertension. Her blood pressure was elevated at most of these visits and there is no evidence that blood pressure medicine was ever adjusted. On one visit she complained of "hearing voices." Respondent responded to this complaint by performing an audiogram (hearing test). There is no chart evidence that Respondent considered the link between this complaint and her history of schizophrenia. On many visits, Patient A.M. complained of "LBP" (low back pain). The physical exam of the "musculoskeletal" and "joint/muscle" systems was invariably marked as "WNL" (within normal limits). On August 6, 2005, despite documenting a normal exam (for which he was paid $24.00), Respondent performed and interpreted a back x-ray for which he was paid $19.39, performed and interpreted a DXA scan ($21.51), and billed for but did not document a facet joint injection ($154.96). The DXA revealed a T-score between -1 and -2 which meets criteria for osteopenia, but Respondent incorrectly rendered a diagnosis of osteoporosis and prescribed Actinal.

P. At an August 19, 2005 visit, Patient A.M. complained of a sore throat; at a September 28, 2005, visit, acute urinary complaints; at an October 8, 2005, visit, acute dizziness; at a November 5, 2005 visit, low back pain; and, at a December 17, 2005 visit, persistent low back pain. A comprehensive physical

exam was done on each of these visits, and none of the exam elements seemed to reflect the patient's chief complaint. Diagnoses did not follow logically from the documented findings, and the plan did not always correlate with the diagnoses. For instance, the diagnostic plan on the back pain visit included obtaining a chest x-ray, the plan on the urinary complaint visit included obtaining an echocardiogram and carotid ultrasound. In addition, on the back pain visit, it appears that a potentially toxic dose (6 grams daily) of Tylenol (acetaminophen) was prescribed.

Q. Patient A.M. also presented to Respondent on November 30, 2005. Respondent documented three different versions of this patient visit. One version is merely cursory; the other two versions are detailed. All three versions are stamped with the same date.

1) The medical history in versions 1 and 3 are similar; however, version 3 includes a complaint of cough for three days. Meanwhile, in version 2, there is no recorded chief complaint and the section corresponding to allergies was left blank. In version 2, Respondent wrote "pain" and what appears to read as "still has intractable low back pain." In version 2, Respondent recorded "SOB" (shortness of breath) without any further details.

2) The vital signs in versions 2 and 3 are notably normal including a normal blood pressure of 110/70.

3) The physical exam portion of version 2 is notable for something illegible regarding the carotid exam, (lung) rales, "PAC" (a kind of premature heart beat that cannot be determined without an EKG), (heart) murmur and a normal prostate. The later notation is especially remarkable given the fact that this is a female patient. In version 3, there are check marks pertaining to all elements of the physical exam, and the aforementioned normal

prostate exam crossed out. There is a new notation indicating that the patient had a carotid bruit [*sic*]. On a separate document, stamped November 30, 2005, there is a detailed evaluation of the patient's restricted range of motion of the lumbar spine and the performance of straight leg testing.

4) Under assessment and plan, in versions 2 and 3, Respondent recorded multiple diagnoses rendered including "HTN with CHF". The diagnosis of HTN (hypertension) is unsupported given Patient A.M.'s normal blood pressure. Nothing other than the word "rales" appearing in the documented physical exam is supportive of the diagnosis of CHF. Nevertheless, Respondent ordered an echocardiogram and carotid ultrasound. The results of both tests were normal. On a consent document, Respondent recorded a diagnosis of "facet joint syndrome" for which he proposed a lidocaine/decadron injection of the lower lumbar spine. The consent is signed but there is no corresponding procedure note.

5) Patient A.M. saw Respondent on multiple other dates in 2004 and 2005. On several of these visits, Respondent documented that she had normal male genitalia and normal female genitalia.

R. The following acts and omissions, considered singularly and collectively, constitute extreme departures from the standard of care:

1) Regarding Patient A.M.'s November 30, 2005 visit, recording multiple versions of a single office visit and, during which, rendering unsupportable diagnoses.

2) Regarding Patient A.M.'s other office visits during and after June 2005, documenting a physical examination

that was not performed as evidenced by the fact that Respondent recorded that the patient had both normal *female* and *male* genitalia.

3) Regarding Patient A.M.'s other office visits during and after June 2005, failing to address Patient A.M.'s hypertension and congestive heart disease properly in that Respondent did not utilize a logical step approach while managing the patient's hypertension and did not prescribe a diuretic for the patient's congestive heart failure.

4) Regarding Patient A.M.'s other visits during 2004 and 2005, failing to chart Patient A.M.'s medications, failing to document the patient's allergy history, and prescribing a potentially toxic dose of acetaminophen also.

5) Regarding Patient A.M.'s other visits during 2004 and 2005, failing to address the patient's complaint of "hearing voices."[7]

6) Regarding Patient A.M.'s other visits during 2004 and 2005, misinterpreting the bone density testing–namely, the DXA scan– as representing osteoporosis rather than osteopenia.

7) Regarding Patient A.M.'s other visits during 2004 and 2005, failing to obtain the standard practice is to obtain a sufficiently detailed medical history to narrow down the diagnostic possibilities suggested by the chief complaint, and then tailor the physical exam accordingly. There is no evidence that Respondent obtained a focused medical history on any of the visits made by this

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7. The typical physician response to this complaint is to inquire about other manifestations of mental illness. Respondent had previously treated this patient with an anti-psychotic medication. His failure to link her history of mental illness with this cardinal sign of psychosis–namely, "hearing voices"-- demonstrates that Respondent lacks a basic knowledge regarding signs and symptoms of psychotic disorders.

patient, nor is there any evidence that the physical exams were done in a diagnostically deliberate fashion. The standard practice is to order lab tests to further narrow the diagnostic possibilities. For instance, an appropriate lab test for a patient with urinary complaints would be a urinalysis. In many of these visits, it appears that Respondent sought justification for ordering x-rays, carotid ultrasounds and echocardiogram but did not obtain less costly but more diagnostically relevant urine and blood tests.

Patient S.B.

R. Patient S.B., a 47 year-old male, with a history of smoking, presented to Respondent on August 2, 2005, requesting a check-up, condoms and complaining of painful urination. The patient's temperature is not recorded, and it is unknown if the patient appeared ill. Except for a slightly abnormal dipstick urinalysis, there are no documented findings to justify the subsequently rendered diagnosis of urosepsis. Non-indicated examinations were done of the ENT and neurological systems, and an evaluation of the patient's psychiatric state was purportedly done as well. The extent or findings of the urological exam is unclear from the medical record. There is no indication that a urine culture was ordered or that specimens or cultures for STD's were obtained. The treatment plan is illegible.

S. Patient S.B. again presented to Respondent on August 17, 2005, complaining of "burning in back of eyes, pressure on neck." A blood pressure of 138/94 was recorded but not specifically addressed. A dipstick urinalysis revealed 1+ leukocytes and a diagnosis of UTI (urinary tract infection) rendered. Respondent's treatment plan called only for "sexual education." Sexually transmitted disease (STD) tests, along with a blood count and blood chemistries, were ordered.

U. No urine was received by the lab for urinalysis or STD testing.

V. Patient S.B. next presented to Respondent on September 6, 2005, to review his blood test results and obtain condoms. An elevated blood pressure of 160/92 was recorded but not addressed. A dipstick urinalysis disclosed 1 + blood, protein and leukocytes. A diagnosis of UTI was rendered and cranberry juice was recommended. No further testing was ordered. No specimens for STD testing were obtained. A new diagnosis of hyperlipidemia was made based on a single non-fasting triglyceride level of 312.

W. The following acts and omissions, considered singularly and collectively, constitute extreme departures from the standard of care:

1) Urinary complaints and a request for condoms raise the question of whether the patient has a sexually transmitted disease (STD). The standard of practice requires a physician to obtain tests for STD. Respondent's failure to test for SDT or to test the patient for gonorrhea or chlamydia during any of the three visits in which Respondent rendered a diagnosis of UTI (urinary tract infection) constitutes a departure from the standard practice of medicine.

2) A blood pressure elevation on two office visits usually results in a diagnosis of hypertension. Treatment of hypertension is especially important in patients with other risk factors for vascular disease as was the case in Patient S.B. who was a smoker. Failure to address this patient's elevated blood pressure constituted a departure from the standard practice of medicine.

3) A single elevated triglyceride on a non-fasting specimen does not warrant a diagnosis of hyperlipidemia. Respondent's unsupported diagnosis constitutes a departure from the standard of care and demonstrates his lack of medical knowledge.

Patient S.R.

X. Patient S.R. presented to Respondent on August 5, 2005. A preprinted history utilized by Respondent is unrevealing apart from a few entries regarding past hospitalizations, exercise, smoking and intake of coffee and alcohol. A preprinted progress notes form utilized by Respondent does not contain an entry for "chief complaint." Under the HPI section, Respondent only recorded "dysuria and burning on urination" and "wants BCP/condom." There is no history regarding duration of symptoms, other urinary complaints (such as frequency, urgency), genital symptoms (such as vaginal discharge, pain with intercourse), fever, back pain, or prior urinary tract problems. There is also no mention of current contraceptive method, last Pap smear[8] or date of last menstrual period. The exam portion of the form is notable for no recorded temperature, an elevated blood pressure of 140/70. There are check marks corresponding to both the female urethra and the male prostate. There is no evidence that a pelvic examination was done. A dipstick urinalysis revealed protein, blood and was positive for nitrates and leukocytes. There is no evidence that pregnancy test was done, although a bill was generated for this. The diagnosis was "UTI (urinary tract infection)" and "R/O Urosepsis." Respondent prescribed Ciprofloxacin in an unknown dose for an unknown duration. Respondent also wrote "Bar study."[9] There was no notation regarding the elevated blood pressure. Respondent reportedly spent an hour with the patient, 30 minutes of which was spent counseling. The patient was advised to return the following week.

Y. The patient's urine sample was received by the laboratory two days later. Although the results were reported by August 9, 2005, Respondent

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8. A Pap smear, also known as a Pap test, is utilized for the detection of the human papilloma virus (HPV). HPV is one of the most common sexually transmitted diseases and is the major cause of cervical cancer.

9. "Bar study" appears to be Respondent's code for sexual education.

did not initial the laboratory report until September 5, 2005, almost one month later. Similarly, the patient's results for the HIV, chlamydia and gonorrhea tests were not initialed by Respondent until almost a month had passed since the results were reported.

Z. Patient S.R. next presented to Respondent on September 5, 2005, for "blood test results." The patient's temperature was recorded as 100 degrees; the patient's remaining vital signs were normal. Again, there are check marks corresponding to the male prostate and the female urethra. On the exam portion of the form, Respondent made notations regarding urinary symptoms. The notes are unclear, however, they reflected current or prior symptoms. A dipstick urinalysis was positive for protein, nitrites and leukocytes. Respondent's diagnoses were identical to the visit of August 8, 2005. Respondent reportedly spent an hour with the patient, 30 minutes of which was spent counseling. The patient was advised to return in one week.

AA. The following acts and omissions, considered singularly and collectively, constitute extreme departures from the standard of care:

1) Failing to obtain a relevant medical history and to perform a relevant physical exam to exclude pregnancy.[10]

2) Inaccurately documenting the genital examination of this patient.

3) Failing to note the date of last Pap or perform

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10. When a female patient complains of painful urination, the standard practice is to take a history that includes duration of symptoms, associated symptoms of the urinary tract and genitals and prior history of kidney and/or bladder infections. It is standard to exclude pregnancy as a confounding diagnosis, since bladder infections in pregnant women can be more aggressive and lead to fetal loss. The standard exam includes all vital signs, comment about the patient's general appearance (sick or well appearing), presence or absence of tenderness in the area of the kidneys and bladder, and a pelvic exam if indicated because of clinical suspicion of disease or genital symptoms. Laboratory studies such as a urinalysis, urine culture and STD studies are commonly obtained.

a Pap smear on a sexually active woman in whom STD's are a concern.

4) Providing two 30 minute sessions of STD education in the span of one month.

5) Diagnosiing urosepsis.

6) Providing treatment for urinary tract infections without having the requisite knowledge, skill and expertise to treat such infections.

7) Taking two days to deliver an urine specimen to the laboratory and taking almost one month to review the laboratory results.

Patient J.H.

BB. Patient J.H., a 46 year-old female saw Respondent on 13 occasions between April 2004 and November 2005. At her initial visit, Patient J.H. reported that she was married and wanted birth control pills. Although Patient J.H. complained of painful urination, Respondent did not perform a pelvic exam. According to Respondent's documentation, an order was placed for laboratory STD screening, but there is no record that this was done. The lab received urine specimens but there was no order for urine culture, gonorrhea or chlamydia testing. Instead of performing "HIV" testing, the lab assayed the patient's liver enzymes. When Patient J.H. returned two weeks later, STD screening was repeated, along with a full urinalysis, CBC, lipid panel and array of hormone levels. All of her tests were normal except for her elevated triglycerides and contaminated urinalysis. It is unclear if her blood was drawn when she was fasting.

CC. Patient J.H. saw Respondent on May 5, 2004, at which time, Respondent recorded the patient's medications to include a blood pressure lowering medication (Mycardis) and an osteoporosis medication (Evista) which are inappropriate for a patient who is taking hormonal contraceptives. This entry does

not appear in any other progress notes prepared by Respondent for this patient. Respondent rendered a diagnosis of "hyperlipidemia" and prescribed a high dose of lipid lowering medication (Lipitor 40 mg, Zetia 10 mg). There is no evidence that he asked if she had been fasting when her blood was drawn, nor is there any evidence that he evaluated her risk for cardiovascular disease.

DD. Patient J.H. returned every three months to obtain a prescription for hormonal contraceptives. At most of these visits, Respondent performed a pregnancy test for which there was no documented justification. On many visits he did a dipstick urinalysis, and often rendered a diagnosis of urinary tract infection. A urine culture was never done. On many visits he documented that she was counseled, presumably regarding pregnancy and STD protection. Total counseling time of this patient amounted to two and one-half hours over an 18 month period. There is no documentation that a pelvic exam was ever performed, even on the August 17 and October 24, 2005, visits when Respondent prescribed medication for vaginal infection.

EE. On October 24, 2005, Patient J.H. requested a Pap smear. The specimen received by the lab was inadequate; there is no documentation that the another specimen was collected and sent for testing.

FF. The following acts and omissions, considered singularly and collectively, constitute extreme departures from the standard of care:

1) Failing to perform a pelvic examination and Pap smear during the first 18 months that he cared for this patient, ordering excessive blood tests, ordering unnecessary pregnancy tests, compelling the patient to return every three months for contraceptive refills, and billing for excessive counseling. Furthermore, Respondent's order for sex hormone assays in a patient using hormonal contraception suggests a lack of medical

knowledge in this area.[11]

2) Failing to perform a pelvic exam on a female patient with vaginal irritation symptoms and persistent urinary complaints and failing to obtain a urine culture at any point.[12]

3) Where, as here, a Pap smear report returns as "inadequate cells for analysis," the usual clinician schedules the patient for a return visit so that the specimen can be collected again. Respondent's failure to repeat the pelvic or mention the need to schedule a repeat Pap smear constitute a departure from the standard of care.

4) The isolated finding of elevated triglycerides leads most clinicians to repeat the test as a fasting specimen. If elevation persists, the patient is counseled to decrease her dietary fat. If after 6 months of diet the triglycerides remain high, medication can be considered. The decision to prescribe medication hinges on the patient's overall risk for cardiovascular

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11. When a married and presumably monogamous 46 year-old female requests contraception, the usual approach is to obtain a complete gynecological and contraceptive history and perform a limited physical that includes examination of the breasts and a complete pelvic exam, including a Pap smear. Contraceptive options are then discussed with the patient. The risks and benefits of the desired method are always reviewed prior to starting therapy. The total time spent in counseling seldom requires more than 30 minutes. Often, a return appointment is scheduled for three months after starting the hormonal method to exclude adverse side effects and insure adherence. Thereafter, patients typically return annually. Patients who are adhering with hormonal contraceptives and whose menstrual periods occur at cyclic intervals do not require periodic pregnancy tests. There is no reason to obtain a hormonal assay on such patients.

12. Repeated complaints of painful urination are typically evaluated with a careful pelvic exam to exclude urethral disease or trauma, a microsopic urinalysis and a urine culture. Infection is treated if detected. Persistent complaints in the absence of infection are often caused by urethral trauma from sexual intercourse. Women in their late 40's can have decreased vaginal lubrication and increased vulnerability to urethral irritation with coitus. The usual approach to a patient with vaginal irritation is to perform a pelvic examination. Such an exam is certainly appropriate before prescribing medication for presumed vaginitis.

disease. Regarding Patient J.H., there is no evidence that she was at risk for heart disease. Respondent's diagnosis of hyperlipidemia was premature; his initial use of medication was excessive and unnecessary. Respondent's failure to repeat the triglyceride test and factor the patient's risk for heart disease suggests a lack of knowledge in the diagnosis and treatment of hyperlipidemia.

5) Erroneously entering the patient's ongoing medications on May 5, 2004.

6) Failing to maintain adequate and accurate records constitutes a departure from the standard of care.[13]

Patient A.A.

GG. Patient A.A., a 35 year-old overweight male, first presented to Respondent on October 29, 1999, complaining of insomnia and back pain. On April 14, 2004, Patient A.A. presented to Respondent, complaining of "mental problems," indigestion, back pain and insomnia. His physical exam was documented as comprehensive, but lacked detail with respect to the back exam. There is a complete and adequately documented psychiatric assessment. Respondent refilled the patient's modestly dosed antipsychotic rispirdol, and added a moderately high dose of the older anti-psychotic thorazine, in addition to new prescriptions for Ativan, Ambien and Tylenol with codeine. Continued complaints of pain and insomnia, two weeks later, prompted Respondent to prescribe Valium and Dalmane. Continued complaints of back pain and insomnia six weeks later prompted Respondent to prescribe Vicodin and Ambien.

HH. Patient A.A. was seen every month, usually complaining of

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13. Respondent's documentation of Patient J.H.'s 13 office visits was below the applicable standard of care in terms of failure to update medication list, the absence of historical detail and lack of clarity regarding which elements of the physical exam were actually performed.

pain and either anxiety or insomnia. On most visits he received prescriptions for codeine containing pain medicine and some kind of sedative. On September 14, 2004, a new antipsychotic was prescribed at the highest recommended dose. Customarily, this medication (Seroquil) is started at a much lower dose and the dose gradually increased. It is unclear if the other antipsychotics were still being taken. On some visits Respirdol was prescribed and on other visits Seroquil was prescribed. On August 8, 2005, both were prescribed.

II. On August 31, 2004, Patient A.A. was prescribed a blood pressure lowering medication by Respondent. It is unclear if this was the first time that this medicine (Coaar) was prescribed. Cozaar was periodically reordered although the patient's blood pressure remained normal. On August 3, 2005, Patient A.A. was given a second blood pressure lowering medicine although the patient's blood pressure was within normal limits.

JJ. With no documented rationale, Respondent obtained a bone density scan for Patient A.A. who had no risk factors for osteoporosis.

KK. The following acts and omissions, considered singularly and collectively, constitute extreme departures from the standard of care:

1) Regarding Patient A.A., Respondent's failure to chart the patient's medications constitutes not only a departure from the standard of care but also a failure to maintain adequate and accurate records pertaining to Respondent's provision of medical services.

2) Prescribing thorazine and the highest of seroquil without first increasing the dosage of rispirdol or consulting with a psychiatrist.[14]

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14. This also shows that Respondent lacked the knowledge, skill, and expertise necessary to treat a patient suffering from multiple psychiatric illnesses.

3) Prescribing six different psychoactive medications during a two week period.

4) Failing to follow a logical and step approach to treating Patient A.A.'s hypertension.[15]

5) Ordering bone density testing when there was no reason to suspect osteoporosis.[16]

Patient L.M.

LL. Patient L.M., a 46 year-old female, saw Respondent once on October 27, 2005. Acccording to her notations on the registration form, she had a history of osteoporosis. According to Respondent's notes, she also had a history of hyperlipidemia. Her medications included lasix, Motrin and Donnatol. She had several complaints including swollen feet and hands, low back pain and insomnia. There is no detail on the progress notes regarding these complaints. Her vital signs were remarkable for an elevated blood pressure of 150/100. Her physical exam notably excluded the heart, but did disclose rales and leg edema. Notations regarding these findings were entered on the wrong line on the pre-printed exam form. There is also a check mark corresponding to "normal scrotum" on the pre-printed form. There is no documented exam of the patient's back. Respondent performed the following tests in his office: dipstick urinalysis (reportedly normal), peripheral DXA (showing high bone density), chest x-ray (read by him as showing congestive heart failure), lumbar spine films (read by him as showing arthritis). Many diagnoses were made including congestive heart failure and hypertension;

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15. Only when the first medication is inadequate in controlling blood pressure is a second medicine added. The standard is to add a second medicine from a different class of anti-hypertensive medications. Respondent's failure in this regard further demonstrates his lack of knowledge, skill and experience necessary to discharge the duties, functions and responsibilities of his medical license.

16. This also demonstrates Respondent's lack of knowledge, skill and experience necessary to discharge the duties, functions and responsibilities of his medical license.

medication was prescribed. Patient L.M. was to return in a week. Multiple lab studies were ordered and subsequently revealed that she had thyroid hormone abnormalities, anemia and high triglycerides.

MM. The usual approach to a new patient with swelling is to perform a detailed history, including kidney disease, salt intake, and heart failure and to inform a patient such as Patient L.M. who is taking Motrin that drugs such as Motrin can cause fluid retention.

NN. The usual approach to a patient complaining of back pain is to obtain a complete history regarding the duration of pain, provoking maneuvers, medications or other sources of relief, trauma, prior diagnoses, etc. This is typically followed by a physical exam in which the spine and corresponding musculature is palpated, range of motion of the low back determined and peripheral nervous system evaluated.

OO. The following acts and omissions, considered singularly and collectively, constitute extreme departures from the standard of care:

1) Ordering x-rays of the lumbo-sacral spine and the chest and bone density testing without adequate support or, in the alternate, without documenting his reasons for such testing.

2) Recording that Patient L.M., a female, had a "normal scrotum."

3) Failing to document a history and perform an appropriate examination of the back.

4) Failing to perform a physical examination focusing on the heart, lungs, peripheral blood vessels and objective signs of edema.

3) Failing to take a detailed history and not advising or, in the alternative, not recording that he advised Patient L.M. of the effects of Motrin.

Patient R.M.

PP. Patient R.M., a 23 year-old actively menstruating female with no significant past medical history, presented to Respondent on August 18, 2005, requesting a Pap smear and complaining of urinary frequency with dysuria. No pelvic exam was done on this visit. Respondent recorded in the patient's record that she had a normal scrotum. Respondent did not record the patient's temperature. A dipstick urinalysis was consistent with menstrual fluid contamination. Respondent diagnosed "UTI" (urinary tract infection) "R/O urosepsis." Respondent's treatment plan appear consist solely of antibiotics. Blood testing was performed, the results of which were normal. Respondent did not test for chlamydia or gonorrhea and did not perform a urinalysis or take a urine culture.

QQ. Eight days later, Patient R.M. returned with vaginitis symptoms. Again, no pelvic examination was performed. Respondent, however, documented that the patient's *prostate* was normal. Respondent rendered a diagnosis of yeast infection, a logical consequence of the antibiotics she was given at the previous visit; however, Respondent prescribed Cleocin intra-vaginally which is not a treatment for yeast vaginitis. Patient R.M.'s Pap was normal except for yeast. Respondent tested R.M. for chlamydia and gonorrhea. The results were negative.

RR. Patient R.M. next presented to Respondent five weeks later. The only notation under history is "UTI X 3 days." Many elements of the physical exam are marked as normal including her neurological exam, nose and, again, *scrotum.* A dipstick urinalysis was weakly suggestive of a urinary tract infection, but a microscopic exam of the urine done later that day suggested contamination of the specimen with vaginal fluids. The urine culture also suggested vaginal flora contamination. Once again Respondent diagnosed "UTI r/o urosepsis" and prescribed antibiotics.

SS. The diagnosis of "UTI" was again rendered on October 24, 2005. The chart on both of these dates had minimal information regarding symptom history and no relevant physical examination. On both visits elements of the *male genital* exam were marked as normal.

TT. The following acts and omissions, considered singularly and collectively, constitute extreme departures from the standard of care:

1) Recording that the patient's male genitalia were normal.

2) Exclusively diagnosing "UTI", even when the objective data did not support this conclusion.[17] Respondent's restricted differential diagnosis of urinary complaints was not only an extreme departure from the standard of care, when considered with other departures, it also demonstrates Respondent's lack of medical knowledge regarding proper treatment of this condition. Similarly, Respondent's casual use of the term "urosepsis" suggests a lack of knowledge regarding the clinical hallmarks of sepsis.

3) The usual treatment of a patient with a vaginal yeast infection is an anti-fungal medication such as miconazole or Diflucan. Respondent's treatment of yeast vaginitis with an intra vaginal antibiotic was not only an extreme departure from the standard of care, when considered with other departures, it also demonstrates Respondent's lack of medical knowledge regarding proper treatment of this condition.

Patient L.T.

UU. Patient L.T., a 62 year-old female, with a history of diabetes

17. Painful urination and urinary frequency in a sexually active young woman can be caused by bacterial urinary tract infections, chlamydia infections, tampon and coital irritation.

and multiple chronic medications, initially presented to Respondent on August 22, 2005. Patient L.T.'s medication allergy history is not documented. Patient L.T. complained of dizziness, nausea and vomiting for three days. She had sustained a fall and reported low back pain for five days. It is unclear for the record if the fall and the onset of back pain were temporally linked. A full physical exam was notable for absent cardiac exam. The extent of the spine and neurological exam is unclear from the chart. The genital exam on one record indicates both male and female findings. Studies ordered included a back x-ray (interpreted by Respondent as revealing "L5-S1 stenosis . . . and degenerative changes") and a DXA scan (done in Respondent's office and showing osteoporosis). Patient L.T. was treated with calcium, Fosamax and Antivert. No blood tests were ordered.

VV. Patient L.T. returned six weeks later, requesting medication refills and reporting syncope and dizziness, and complaining of abdominal pain, a history of fatty liver, leg cramps and cold feet. There is no further detail regarding these complaints. Elements of the physical exam are checked as having been done, including the *male* and female genital exam. The pedal pulses notably are checked as being normal. Inexplicably, Respondent rendered diagnoses of "renal failure" and "peripheral vascular disease." He ordered ultrasound examinations of the carotid arteries, abdomen and kidney- these studies were accomplished later that day at the imaging center next door to his office. They were interpreted by a board certified radiologist and determined to be essentially normal. No blood tests were ordered.

XX. The following acts and omissions, considered singularly and collectively, constitute extreme departures from the standard of care:

1) Failing to document the allergy history or provide detail regarding the dosing of current medications, failing to note the inconsistencies within the medication list, and failing to address the possibility that the patient's symptoms were linked to

medicine misuse.[18]

2) Failing to perform blood testing on this patient.

3) Prescribing Fosamax, a known stomach irritant, to a patient complaining of nausea and vomiting.

Patient H.C.

YY. Patient H.C., a 22 year-old unmarried female, presented to Respondent on August 5, 2005. No significant medical history is recorded on the registration form signed by the patient. On the progress note form, the chief complaint recorded in handwriting unlike that of Respondent is "heavy menstrual period...cramps...back pain." Respondent then wrote "(History) of polymenorrhea...(history) of UTI; dysuria." There are check marks throughout the physical exam portion of the form, including *male* genitalia. There is an "X" next to "WNL uterus" and the notation: dysuria polyuria. There is no written information regarding physical findings and it is unclear if a pelvic exam was performed. The only recorded vital sign is a blood pressure of 98/illegible. A dipstick urinalysis was normal except for positive nitrites which Respondent interpreted this as indicating a "mild UTI." Diagnoses of "polymenorrhea, UTI, BCP". Motrin and birth control pills were prescribed, cranberry juice recommended and the patient advised to return in one week.

ZZ. Patient H.C. again presented to Respondent on August 11, 2005. Respondent documented the chief complaint as "refill." Respondent also recorded only "still has fever UTI." There are numerous check marks

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18. Upon seeing a patient on multiple medications for the first time, the usual practice is to clarify what medicines are actually being taken. Patient L.T. reported taking 3 different medications for her diabetes, but two of these medicines were from the same pharmaceutical class and there is no notation regarding dosing frequency. She is also taking two different doses of Neurontin, two antidepressants and Popranolol. None of these medicines correlate with a documented diagnosis. Many of these medicines, either alone or in combination, could have caused her dizziness.

corresponding to normal elements of the physical exam, including normal *penis*. There is an "X" next to "WNL urethra" beside which Respondent wrote "dysuria." The temperature is illegible but less than 100 degrees. A dipstick urinalysis shows 2+ blood and few leukocytes. A diagnosis of urinary tract infection was made for which "Z-pk-6" (presumably 6 tablets of azithromycin) was prescribed. Vitamin B6 and condoms were also either prescribed or dispensed.

AAA. Comprehensive blood tests done on August 12, 2005, were normal except for mild anemia. No urine was sent to the lab for testing or culture, thus the patient was not tested for chlamydia or gonorrhea.

BBB. The following acts and omissions, considered singularly and collectively, constitute extreme departures from the standard of care:

1) Regarding Patient H.C.'s August 5, 2005 visit, Respondent failing to take an adequate medical history, to perform a pelvic exam and to obtain a pregnancy test, but nevertheless diagnosiing "polymenorrhea."

2) Failing to inquire about or document the duration of Patient H.C.'s urinary symptoms and document any associated symptoms such as fever or vaginal discharge.

2) Inaccurately documenting that Patient H.C.'s genitalia were normal.

4) Ordering excessive blood tests.

Patient A.S.

CCC. Patient A.S., a 54 year-old male with longstanding back pain, presented to Respondent. Multiple tests were ordered, including x-rays, a carotid ultrasound, a venous Doppler and an echocardiogram. Respondent also ordered bone density testing–a DXA scan–without indication.

DDD. During a follow-up visit three weeks later, September 7, 2005, Respondent recorded "pain back and legs...can't even walk or stand." The

physical exam is remarkable for a check marks corresponding to normal "gait or posture," and normal *female* genitalia. A CT scan was ordered of the neck and back, Halcion and Vicodin-ES refilled and new prescriptions for Duragesic patch and Ativan written. There is a notation "refer to orthopedic (sic)."

EEE. The following acts and omissions, considered singularly and collectively, constitute extreme departures from the standard of care:

1) Ordering bone density testing on a patient who was at low risk for osteoporosis; and rendering a diagnosis of osteoporosis and prescribing calcium supplements for a male patient with a normal T-score.

2) Diagnosing carotid stenosis in light of the physical examination recorded by Respondent and heart failure in light of the absence of any supportable physical findings. The documented physical exam is sometimes grossly inaccurate (normal female genitalia) or probably inaccurate (check mark corresponding to normal gait/posture).

3) Documenting that a male patient had normal female genitalia.

Patient E.G.

FFF. This 53 year old female homemaker presented to Respondent's office on December 5, 2005. The registration form is incomplete, with "N/A" (not applicable) recorded in the box for past medical history, and medication use beyond multivitamins unknown. Multiple elements of the review of systems are checked as positive including: headache, blurred vision, joint pain, back pain, difficulty walking, nervousness, depression, blood in stool, urinary frequency and hepatitis. Next to hepatitis is ambiguously written "E.G."

GGG. On the progress note form, the chief complaint entered by Respondent is: "c/o (complains of) severe pain in (illegible), c/o LBP (low back

pain), abnormal vision, lack of void; numbness of wrist (for).1 month radiating down to hand, c/o whole body is hurting, c/o migraine headache." There are check marks corresponding to most elements of the physical exam including the male genital exam. These marks presumably denote normal findings. Next to "general appearance," a check mark is altered to look like an "X", and Respondent has recorded "migraine H/A." Some elements of the musculoskeletal exam have "+" marks or "x" marks alongside with largely illegible notations. Recorded vital signs are notable for weight 94 lbs, blood pressure 140/80; the pulse, respiratory rate are normal and the height not recorded.

HHH. Respondent did several X-rays in his office and a peripheral DXA. The x-rays are not available for my review but interpreted by Respondent as showing arthritis in the low back and right wrist. According to Respondent's notes, the DXA revealed osteoporosis. However, the computer generated report rendered a diagnosis of "normal" based on a T-score of -0.7.

III. Diagnoses were largely a recapitulation of the chief complaints (LBP, forearm & wrist pain, migraine headache) except for a new diagnosis of osteoporosis. The plan included calcium supplements and monthly Fosamax (which are treatments for osteoporosis) and Motrin (presumably for pain). A CT scan of the low back was ordered, done the next day, and revealed lumbar stenosis and moderate disc disease. On the CT report, Respondent wrote "refer to orthopedic (sic)". This referral is referenced at a later visit (12/17/05) but there is no evidence that it was ever accomplished.

JJJ. Patient E.G. returned three days later, on December 8, 2005, with a recorded chief complaint "she cannot move her whole body, very depress (sic)". In the HPI section, Respondent recorded: "c/o migraine headache, severe neck pain & back pain, very depressed, pain not relieved by Rx." There are check marks corresponding to most elements of the physical exam including a normal male genital exam and normal psychiatric exam. Range of motion of the back is

recorded as restricted on a separate form. A check mark next to "WNL nose" has been altered to resemble an "X" with the handwritten notation "sinus." Most other notations on the physical exam portion of the form record the patient's complaints of pain and do not reflect objective exam findings. X-rays of the sinuses and neck were done in the office and interpreted by Respondent as revealing sinusitis and stenosis of the neck with bone spurs and osteoporosis. The patient was consented for a procedure "facet joint injection with ....lidocaine ...decadron to (lumbar spine levels 3-5)." There is a vague drawing in the plan section of the progress note documenting this procedure but there is no procedure note per se. Respondent records a "psych consult for 30 minutes" but his findings are not recorded beyond the check marks indicating a normal psychiatric exam. Nevertheless, a diagnosis of depression was rendered and an antidepressant (Zoloft) prescribed. For pain, Respondent initially prescribed "Tylenol 3" but this was crossed out and Vicodin written above. Both of these drugs contain codeine or a codeine derivative yet the patient reported an allergy to codeine when she registered 3 days earlier. Respondent also wrote: "P.T. (physical therapy) needed" but there is no indication if the patient was referred to a physical therapist.

KKK. On December 17, 2005, Patient E.G. again presented to Respondent, for "CT result, blood test." Respondent's notations in the HPI section are largely a recapitulation of the CT scan results, except that he also notes "arthritis of hips for long time." Vital signs are normal, ambiguous check marks are made in scattered sections of the physical exam section including the male genitalia. Diagnoses include "arthritis of hip bilateral with pelvic pain" although there is no corresponding examination of the hips or pelvis recorded. A urinalysis and array of blood tests impertinent to the medical history were ordered. All were essentially normal.

LLL. The following acts and omissions, considered singularly and collectively, constitute extreme departures from the standard of care:

1) Failing to obtain an adequate history and incorporating a review of the past medical history, including chronic medical conditions, prior treatments and prior treating clinicians.

2) Failing to address Patient E.G.'s "blood in the stool."

3) Failing to perform a physical examination of the patient's lower back, wrist and hip in light of her complaints of pain in those regions.[19]

4) In evaluating a patient complaining of depression, failing to take an additional history, including but not limited to, duration of symptoms, associated symptoms (such as sleep disturbance, concentration or memory difficulties, anxiety), prior history of depression or bipolar disease, substance use (alcohol, drugs of abuse), and suicidal thoughts.

6) Recording that the male genitalia of this female patient was examined.

7) Ordering x-rays are typically without first taking an appropriate history or performing an adequate physical examination.

8) Erroneously diagnosing Patient E.G. with

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19. The examination of a patient presenting predominantly with low back and wrist pain is a detailed inspection of those regions of the body, and this is not evidenced in Respondent's progress notes. Common allopathic (M.D.) notations regarding exam of the low back include findings on lumbar inspection (altered curvature or gross deformities), palpation (areas of tenderness or other abnormalities) and range of motion. Neurological examination of the lower extremities with a straight leg raising testing is also usually performed. The back exam of an osteopathic physician (D.O.) such as Respondent is typically more detailed than that done by a M.D. An inspection of the wrist typically includes inspection for swelling or redness, areas of discrete tenderness, palpable abnormalities, range of motion, and an assessment of function of muscles and nerves in the hand. There is no evidence that the physical examination conducted by Respondent on December 5 or 17, 2005 included any of these elements.

having osteoporosis.

9) Failing to obtain or, in the alternative, to record the patient's prescription and medication allergy histories.

10) Prescribing Vicodin to patient who was reportedly allergic to codeine.

11) Prescribing Fosamax to a patient with a normal DXA scan and no fracture history

12) Prescribing Zoloft when there was no evidence that Patient E.G. was suffering from clinical depression.

13) Failing to follow through with referring the patient for physical therapy.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

15. Respondent's Osteopathic Physician and Surgeon's License is subject to disciplinary action in that he has committed repeated negligent acts during his care, treatment and management of patients, in violation of Business and Professions Code section 2234, subdivision (c), as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraph 14, above, as though fully set forth.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

16. Respondent's Osteopathic Physician and Surgeon's License is subject to disciplinary action in that he lacks the knowledge, training and expertise to discharge his duties, functions and responsibilities as an osteopathic physician and surgeon, in violation of Business and Professions Code section 2234, subdivision (d), as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraph 14, above, as though fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Repeated Acts of Clearly Excessive Treatment)

17. Respondent's Osteopathic Physician and Surgeon's License is subject to disciplinary action in that he engaged in repeated acts of clearly excessive treatment, including but not limited to, unnecessary bone density testing, in violation of Business and Professions Code section 725, as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraph 14, above, as though fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

18. Respondent's Osteopathic Physician and Surgeon's License is subject to disciplinary action in that he failed to maintain adequate and accurate records relating to the provision of his services to patients, in violation of Business and Professions Code section 2266, as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraph 14, above, as though fully set forth.

SIXTH CAUSE FOR DISCIPLINE

(Practicing Under Fictitious Name Without Permit)

19. Respondent's Osteopathic Physician and Surgeon's License is subject to disciplinary action in that he practiced medicine under a fictitious name without obtaining an approved fictitious name permit, in violation of Business and Professions Code section 2285, as follows:

A. Prior to, through and including October 21, 2007, Respondent's medical practice was named and advertised as the "Wellcare Comprehensive Medical Group." Not until October 22, 2007, did Respondent have an approved fictitious name permit for "Wellcare Comprehensive Medical Group."

PRIOR DISCIPLINARY CONSIDERATION

20. Not as a separate ground for discipline but, rather, to determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about December 19, 2001, in a disciplinary action entitled *In the Matter of the Accusation Against: Po-Long Lew, D.O.*, before the Osteopathic Medical Board of California, in Case Number 99-14, OAH No. L2001040342, Respondent's license was revoked. At the same time, the revocation was stayed and Respondent placed on probation for five years subject to terms and conditions, among others, that Respondent complete the Physician Assessment and Clinical Education (PACE) program, an approved medical record keeping course, and an approved professional ethics course. Respondent's probation terminated on or about December 19, 2006.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Osteopathic Medical Board of California issue a decision:

1. Revoking or suspending Osteopathic Physician and Surgeon's License Number 20A 5380, issued to Po-Long Lew, D.O. Po-Long Lew, Po-Long Lew, D.O..

2. Ordering Po-Long Lew to pay the Osteopathic Medical Board of California the reasonable costs of the investigation and enforcement of this case up, pursuant to Business and Professions Code section 125.3; and, if placed on probation, the costs of probation monitoring; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: 6/24, 2008.

DONALD J. KRPAN, D.O.
Executive Director
Osteopathic Medical Board of California
Department of Consumer Affairs
State of California
Complainant

LA2008501070

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